

Patient Name: _____ Date of Birth: _____ Date of Visit: _____
 Cell Phone: _____ Home Phone #: _____
 Email: _____ Can we correspond by email and phone? Y N
 Emergency Contact Phone #: _____ How did you hear about us? _____

1. What is your main complaint or problem? (if your health is good and you are looking for wellness/prevention medicine, please skip to section 2)

Please give a brief description of your problem (specifically include when it began, what caused it, if known and what is happening currently):

List other problems you would like to address:

What was your health like before problems began?

2. LIFESTYLE:

SMOKING

- No tobacco use
- 1 pack/day
- 2 packs/day
- <2 packs/day

ALCOHOL

- No alcohol use
- Positive alcohol consumption
 - Rarely
 - Socially
 - Daily
 - Current alcoholic
 - Recovering alcoholic

EXERCISE

- No regular exercise program
- Exercises 1-2 times per week
- Exercises 3-4 times per week
- Exercises 5-6 times per week
- Exercises daily – how many hours per day? _____

SLEEP (check all that apply)

- I sleep good usually about _____ hrs per night
- I sleep good most nights but do have some trouble from time to time
- I fall asleep fine but wake up throughout the night
- I have trouble falling asleep
- I have trouble both falling asleep and staying asleep
- I DO NOT feel rested even if I think I slept well

STRESS

- I have very little stress in my life
- I have some stress in my life
- My life is stressful most days
- I deal with the stress in my life very well
- I sometimes struggle with how to deal with the stress in my life
- I am not doing very well in dealing with the stress in my life

I DO THE FOLLOWING TO HELP WITH MY STRESS (check all that apply)

- Exercise
- Meditate or pray
- Use breathing techniques
- Do biofeedback
- Take medication

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DIET

- What is a typical breakfast? _____
- What is a typical lunch? _____
- What is a typical dinner? _____
- What is a typical snack and how often do you consume them? _____
- What type of foods do you crave? (ie salty, carbohydrates, sweets or proteins etc) _____

3. Please check any major medical problems that you have or have had in the past:

- No major medical problems

HEART PROBLEMS

- Coronary artery disease
(heart attack, angina)
- Hypertension (high blood pressure)
- Cardiac arrhythmia
- Heart murmur
- Hypercholesterolemia
(cholesterol problems)

STOMACH PROBLEMS

- Chronic or intermittent diarrhea
- Constipation
- Reflux disease (GERDS)
- Abdominal pain/bloating/cramping
- Gallbladder problems
- Hepatitis
- Cirrhosis

AUTOIMMUNE/IMMUNE PROBLEMS

- Systemic Lupus
- Multiple Sclerosis
- Chronic Fatigue Syndrome
- Fibromyalgia
- Hypothyroidism
- Hyperthyroidism
- Chronic or recurrent yeast infections

LUNG/RESPIRATORY PROBLEMS

- Chronic or recurrent sinusitis
- Chronic or recurrent upper respiratory infections
- Seasonal allergies
- Asthma
- Chronic obstructive pulmonary disease
(COPD/emphysema)

JOINT/BONE PROBLEMS

- Osteoporosis
- Degenerative joint disease
- Osteoarthritis
- Rheumatoid arthritis

URINARY PROBLEMS

- Chronic or recurrent urinary tract infections
- Kidney stones
- Prostate problems (male only)
- Renal disease
- Urinary incontinence

BLOOD PROBLEMS

- Anemia
- HIV

NUTRITIONAL PROBLEMS

- Vitamin B12 deficiency
- Diabetes
- Glucose intolerance
- Vitamin D deficiency

SKIN PROBLEMS

- Chronic or recurrent rash
- Psoriasis
- Excessive hair growth
- Hair loss

MENTAL HEALTH PROBLEMS

- Depression
- Anxiety
- Bipolar Disorder
- Schizophrenia
- Alcoholism

CANCER

- Breast cancer
- Prostate cancer
- Leukemia/Lymphoma
- Others _____

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4. Please list any over-the-counter medications and/or any supplements that you are taking:

Name of supplement	Dosage	How often do you take your supplement?	Regularly	As needed

5. Please list any allergies to medications or foods?

Do you have increased sensitivities to things in your environment like perfumes, chemicals etc?

6. Please list your current medications (do not include any hormones):

Name of medication	Dosage	How often do you take your medication?	Regularly	As needed

7. Past medications tried and why you stopped taking them (do not include any hormones):

Name of medication	Dosage	How often was the medication taken?	Why did you stop taking it

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Please check:

8. Past surgeries (what year was your surgery):

- No prior surgeries _____
- Tonsils removed _____
- Appendix removed _____
- Gallbladder removed _____
- Hysterectomy _____
- Disectomy _____
- Spinal fusion _____
- Skin lesions removed _____
- Breast lumps removed _____
- Other _____

9. Diseases in your family (include what family member has each disease):

- High blood pressure _____
- Heart disease _____
- Strokes _____
- High cholesterol _____
- Diabetes _____
- Thyroid disease _____
- Arthritis of the spine _____
- Arthritis of joints _____
- Thinning of bones _____
- Breast cancer _____
- Colon cancer _____
- Prostate cancer _____
- Lung cancer _____
- Other _____

10. Occupational History:

What is your current or most current occupation? _____

How much do you like your work on a scale of 1 to 5 (1=very little, 5=very much): _____

Are you: Employed (how many hours per week do you work? _____) On disability (started when? _____)
 Unemployed Retired

Does your health affect your ability to perform duties at work? Explain: _____

Does your health interfere with your ability to enjoy hobbies and social activities? Explain: _____

11. Is there anything else about your medical history that we should know? _____

FEMALE HORMONE EVALUATION

Patient Name: _____ Date of Birth: _____ Date of Visit: _____

MENSTRUAL HISTORY (if post-menopausal please skip this section)

1. PMS, or premenstrual syndrome, is defined as a condition in which a variety of symptoms may occur during the 7 to 14 days before a menstrual period begins. Please check any symptoms you currently experience or have experienced in the past from the list below:

- | | | |
|--|---|---|
| <input type="checkbox"/> Mild physiological discomfort | <input type="checkbox"/> Bloating | <input type="checkbox"/> Weight gain |
| <input type="checkbox"/> Swelling of hands and feet | <input type="checkbox"/> Breast tenderness | <input type="checkbox"/> Aches and pains |
| <input type="checkbox"/> Poor concentration | <input type="checkbox"/> Sleep disturbances | <input type="checkbox"/> Change in appetite |

How would you describe your PMS in the past?

- Didn't notice Sometimes Each time Severe

Do you currently suffer from PMS? Yes No If yes, what time of month? _____

As you have aged, has your PMS worsened? Yes No

2. Describe your menstrual periods presently (check all that apply):

- | | | | |
|------------------------------------|---|--|---|
| <input type="checkbox"/> Regular | <input type="checkbox"/> Light | <input type="checkbox"/> Sporadic | <input type="checkbox"/> Brown blood |
| <input type="checkbox"/> Irregular | <input type="checkbox"/> Heavy | <input type="checkbox"/> No periods | <input type="checkbox"/> Bright red blood |
| <input type="checkbox"/> Clotty | <input type="checkbox"/> Premenstrual spotting (≥ 3 days) | <input type="checkbox"/> Postmenstrual spotting (≥ 3 days) | |

3. Have you ever had cramping or pain with your period? Yes No

4. Have you ever skipped periods all together? Yes No

5. When was your last menstrual period? _____ How long is your cycle? _____ days

6. Do you have any bleeding between periods? Yes No When? _____

OBSTETRICAL HISTORY

1. Are you sexually active? Yes No If yes, please check how frequently you have sex below:

- Rarely Sometimes Often

Are you satisfied with this level of sexual activity? Yes No

2. Are you trying to get pregnant? Yes No

3. Current method of birth control? _____ How long? _____

4. Past birth control and any related problems? _____

5. Have you ever had children? Yes No

6. Number of: pregnancies _____ deliveries _____ miscarriages _____

FEMALE HORMONE EVALUATION

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GYNECOLOGICAL HISTORY

1. When was your last test:

- Pap smear _____
- Bone density _____
- Cholesterol _____
- Hormone panel _____
- Mammogram _____
- Thyroid panel _____

2. Have you ever taken hormones (synthetic or natural) before? Yes No

If yes, please list the hormone medication(s) you have used on the lines below:

	Drug name	Strength	When used	Side effects	Benefits
1.					
2.					
3.					
4.					
5.					

3. If you have discontinued the use of hormones, please briefly explain why. Additionally, please explain why you are seeking bio-identical hormone replacement therapy (HRT). _____

4. Have you tried any alternative therapies or taken any herbal or homeopathic products? Yes No If yes, please list them here: _____

5. Have you had a hysterectomy? Yes No If yes, when? _____

6. Have you had any part of or your whole ovary removed? Yes No If yes, when? _____

7. Have you ever had a tubal ligation? Yes No If yes, when? _____

8. Have you ever had an abnormal pap? Yes No If yes, what was the abnormality and how was it treated? _____

9. Please check any of the following conditions you have had in the past or currently have:

- | | | |
|---|---|--|
| <input type="checkbox"/> HSV (vaginal herpes) | <input type="checkbox"/> Cervical cancer | <input type="checkbox"/> Breast fibroids |
| <input type="checkbox"/> HPV (vaginal warts) | <input type="checkbox"/> Cervical dysplasia | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Ovarian cysts | <input type="checkbox"/> Pelvic infections | <input type="checkbox"/> Acne |
| <input type="checkbox"/> Increased facial and/or body hair growth | <input type="checkbox"/> Uterine fibroids | |

10. Is there any family history of breast cancer? Yes No If yes, who and what age were they diagnosed? _____

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*Please rank the severity of each symptom listed below
0 = no symptoms
10 = very severe symptoms*

LOW ESTROGEN

- Dry skin*
- Heart palpitations
- Hot flashes
- Night sweats
- Vaginal dryness or irritation
- Decreased sex drive*
- Painful intercourse
- Urinary track infections/irritation
- Thinning skin
- Osteoporosis
- Urinary incontinence
- Recurrent yeast infections
- Depression*

LOW TESTOSTERONE

- Decreased sex drive*
- Diminished feeling of well being
- Difficult to reach orgasm
- Prolonged fatigue*
- Aches and pains (muscle/joint)*
- Muscle weakness

LOW THYROID

- All day fatigue
- Dry skin*
- Dry, brittle hair
- Hair loss
- Depression*
- Lack of interest (apathy)
- Loss of enjoyment
- Difficulty focusing
- Carbohydrate craving*
- Constipation
- Cold intolerance
- Depression*

LOW PROGESTERONE

- Anxiety
- Menstrual cramping
- Insomnia
- Mood swings
- PMS
- Irregular menses/periods
- Endometriosis
- Uterine fibroids
- Swollen tender breasts
- Water retention
- Acne/oily skin
- Aches and pains (muscle/joint)
- Headaches
- Ovarian cysts
- Fibrocystic (lumpy) breasts
- Irritability*
- Carbohydrate craving*

LOW CORTISOL

- Fatigue (morning and afternoon)
- Difficulty concentrating
- Sleep disturbances
- Memory problems
- Depression*
- Dry skin*
- Irritability*

**** because hormones need to be balanced, you may see the same symptom in several deficiencies*

FEMALE HORMONE EVALUATION

Patient Name: _____ Date of Birth: _____ Date of Visit: _____

How do you feel when you wake up?

How well do you sleep?

What is your energy level?

Do you have any bloating, constipation or other gastrointestinal symptoms?

Thank you for you time!